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Mental Hospitals

Volume 4 Number 9

in this issue:

Dr. Daniel Blain, Medical Director, A.P.A. presents the 1953 Achievement Awards to winning superintendents: L. to R.: Dr. Daniel Lieberman, Asst. Supt., Sonoma State Hospital, Eldridge, Calif., Dr. E. S. Post, Manager V.A. Hospital, Sheridan, Wyo., Dr. Edward Johnson, Med. Supt., Selkirk Mental Hospital, Man. Canada, Dr. Blain, Mrs. Anna T. Scruggs, Supt. Enid State School, Okla., and Dr. Gale H. Walker, Supt. Polk State School, Pa.

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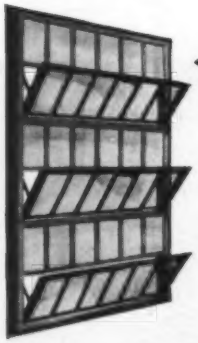

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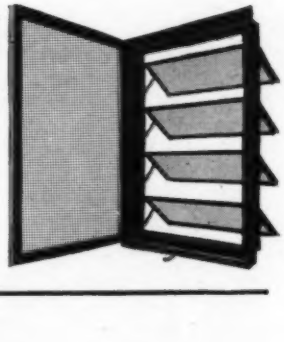

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THIS MONTH'S COVER

Already, it was stated during the Faculty Dinner of the Fifth Mental Hospital Institute, these hospital meetings have developed their own traditions. Among them is to publish in MENTAL HOSPITALS the picture of the Achievement Awards presentations. Unfortunately our cover picture of this event did not include Dr. R. C. Steck, Superintendent of Anna State Hospital, Ill., one of those who received an Honorable Mention. Dr. Steck did not reach Little Rock until the following day.

At the Institute Dinner, Dr. Daniel Blain told delegates that this was the largest attendance so far at any Institute—a total of 271 delegates, representing 7 Canadian Provinces, 45 States, the District of Columbia and Hawaii. Of these delegates, about 40% were from hospital disciplines other than medicine—the largest lay attendance at any Institute.

The location of the Sixth Mental Hospital Institute will be announced later. The third week in October will continue to be "hospital institute week."

Another "institute tradition" which was jealously guarded was the principle of free open discussion from the floor, with a minimum of prepared papers. An exception to this was yet another tradition—the Academic Lecture, delivered this year by Dr. Henry Weihofen, of the College of Law, University of New Mexico.

The Local Arrangements Committee, under the Chairmanship of Dr. Cleve C. Odom, arranged three bus tours to local hospitals—the Arkansas State Hospital, the Veterans Administration Hospital at Little Rock, and the V.A. Fort Roots Hospital at North Little Rock.

This Committee was also responsible for obtaining the outstanding volunteer help, both from Gray Ladies from the local hospitals, and from several of the hospital secretaries. The generous assistance of these ladies greatly eased the administrative burden on the staff.

"These Institutes are workshops—not official, decision-making bodies," said Dr. Blain. "We meet together to try to discuss our problems and our ideas about solving them."

The staff members of Mental Hospital Service who attend the Institutes find them fine educational tools. From these meetings come evaluation of the work of the year just past, ideas for the coming year, and a renewal of purpose and enthusiasm.

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PATIENTS SHARE IN ECONOMY PROGRAM TO IMPROVE CARE

Suitable Occupational Assignments Increase Farm Production and Patients Benefit both from the Work and Increased Funds

By CHARLES H. JONES, M.D.

Superintendent, Northern State Hospital, Sedro-Woolley, Washington

Status quo appropriations and the desperate need for improved patient care and treatment often seem to be irreconcilable factors in the operation of a mental hospital. Nonetheless, during the years 1950, 1951 and 1952, we have managed, through increased farm production, to make $175,000 more available for the welfare of the patients, without receiving a single increase in appropriations or a single outside gift or contribution.

Taking stock of our total operation in 1950 we found several factors which hindered optimum achievement. Among them was the lack of an organized system for making occupational assignments for convalescent patients, inefficient farm operations and lack of a properly integrated supply requisition system. Because of chronic shortages of supplies, interdepartmental competition for stores led to stockpiling whenever chance presented. Each department was run as a competing unit, and operations needing cooperation were often handicapped.

The first step was both therapeutic and administrative. We set up a system to provide each eligible patient with a suitable occupational assignment. An attendant supervisor, intimately familiar with the whole hospital, was given the full-time responsibility for this program. All diagnostic work-ups and ward transfer slips containing physicians' recommendations for patient assignments were routed to him. A specially designed card recorded pertinent information, and a file of completed cards provided a constant back-log of patients available for different assignments. Transfer slips were designed to include space for recommendations for a change of occupation.

Policy of "Therapeutic Assignment"

In assigning patients, the attendant supervisor worked closely with the medical staff. The practice was established of scheduling patients for parole consideration a week in advance to give ample time for the recruitment of suitable replacements and to allow the patient to be discharged time to train his successor.

The therapeutic effects of this work assignment program were quickly apparent. The promotion of a patient made in consultation with ward physicians is interpreted by him as evidence of his individual progress. The intimate knowledge of the occupational progress of patients has helped social workers in making parole and discharge placements and in helping physicians to decide when a patient is ready for release. It is our impression that hospital time has been reduced because of this more intimate knowledge.

Reduction of Dependency

The job-training of a patient by another patient about to be discharged from hospital has the effect of directing the new worker's attention to the probability of his own ultimate release. It serves as a hopeful reminder to patients and their families that we do not regard mental illness as a permanent disability. The rehabilitation of patients so that they can do a day's work in harmony with others and their subsequent discharge has reduced dependency and in some measure helps to overcome the evil of "institutionalization."

The second step was to expand existing farm operations. Labor-saving machinery was purchased and modern technological advances in agriculture were put into operation. The man power released by the use of new machinery and the additional man power made available by the new system of patient classification permitted the planting of additional acreage in food crops, especially those needing hand cultivation. Cold storage facilities and canning operations were added to handle "surplus" production. During the winter months farm crews cleared many acres of upland pasture when the weather was favorable. Large barns and loafing sheds were built with hospital-produced lumber and a beef herd was established.

Planning Saves Money

The third step was the integration of the procurement system. Department heads met every three months to prepare budget requests, and thus became familiar with the accounting system used by the state and with the financial interrelationship of the various hospital departments. The manner in which lax planning and faulty operation in one department adversely affected others was demonstrated all too often until everybody learned that funds saved in one department might make possible the purchase of badly needed supplies or equipment in another.

The quarterly budgets were approved after considerable inter-departmental discussion and now each department head has the responsibility of submitting his own orders and requisitions to ensure a steady and proper flow of supplies.

Patient morale has risen enormously since the patients themselves have sensed the efforts of employees and other patients to run the hospital more efficiently. They identify themselves with the changes and take personal pride in their own contributions to the common good.

The use of occupational classification cards has allowed the assignment of large groups of patients to departments not previously favored. Of special value to the hospital operation has been the screening of short-term patients. Often a skilled worker, such as a brick mason, carpenter, or plasterer has been discovered and given a special job compatible with his expected convalescence. The accumulative benefit to hospital maintenance programs has been remarkable. All departments using patient help

are running efficiently and in several instances get along with fewer employees than before.

The saving of funds in salaries and wages as well as in operations has increased the quality of patient care and treatment. We have been able to increase the size of the medical staff from 7 to 13 physicians, and the nursing staff from 12 registered nurses in 1949 to 17 in 1953. Many new items of medical equipment have been purchased. Treatments needing high-priced medications are now financed by the hospital instead of by relatives.

Many wards have been repainted, others completely remodelled. A new water-line, the money for which was taken out of operating funds, has increased the water supply so that frequent bathing is possible. Antique plumbing fixtures are being replaced and dishwashing facilities have been installed.

Shortage of ward supplies such as linens, bedspreads, patients' clothing, etc. is a thing of the past. New plastic dishes have replaced the old aluminum table ware and knives and forks have been supplied to wards where formerly only spoons were used. The quality of the food has been much improved; the quarterly food allotment of $96,000 for the January-March period in 1950 was increased to $120,000 for the same quarter in 1953.

This is only the beginning. Now that we have overcome the chronic shortage of supplies, we intend to use the money saved by increased farm production to expand treatment programs and to improve patient care further. Most important, perhaps, is the active participation of the patients themselves in this overall improvement program.

Clothing

CLOTHING COMMISSARY REPLACES SEWING ROOM

Several months ago the sewing room of Larned (Kans.) State Hospital was closed and a Clothing Commissary took over the task of supplying patient clothing. This was done because it was found to be less expensive and also better, psychologically, for the patients.

The Commissary is fitted out like a small department store. Women's dresses are hung out on racks according to size. The patients may try on several dresses in front of the full-length mirror before deciding which one to take. There is a wide variety of cotton prints, colors, and styles from which to choose. Men patients especially enjoy the shoe section, where they can be fitted with shoes, in black or brown. The hospital feels that the free choice permitted not only affords the patients much pleasure, but also augments their progress in therapy.

The Commissary is in charge of a storekeeper who has three regular assistants. It also supplies linens and towels for the wards. Some of the former sewing room employees work there, repairing torn linens and operating the marking machine. A few items are still made—such as extra-large size garments and kitchen towels. Other employees have been assigned to the ward clothing rooms, where garments in use are repaired. (8-2)

Mental Defectives

CANADIAN SCHOOL SOLVES ELOPEMENT PROBLEM

When the elopement rate at the Provincial Training School, Red Deer, Alberta, hit a peak of 46% in 1950, the school staff, under the direction of Dr. L. J. le Vann, Medical Superintendent, undertook to discover the causes and correct them. Their success is reflected in the current elopement rate—only 1.6%.

As a first step, a special staff group was formed to interview each returned escapee to learn the reason he ran away. The findings resulted in improvements which have had far-reaching effects.

Such complaints about the staff as their being "too bossy" and unsympathetic in their treatment of the children, have been virtually eliminated by establishing higher qualifications for employment. Recreation and occupational therapists were employed to ensure that all children were kept happily active.

The staff improvement has aided the success of other programs. Disciplinary measures were replaced by an incentive plan. Special reward for good behavior was emphasized, instead of punishment for bad behavior. Some of the major complaints from the runaways had been that "it made no difference if we behave good or bad", and that any difference of opinion between children and staff resulted in seclusion in the "Quiet Room". The children are now encouraged to air their feelings in consultation interviews.

A program of community education was indicated. Senior staff members sought opportunities to speak before civic and social organizations on mental health subjects. Local townspeople were urged to visit the school, and this has often led to their inviting the children to their homes for weekends and holidays. One small change which helped was to refer to the children as "trainees" rather than "patients" . . . formerly unsympathetic employees and townspeople referred to the children as being "crazy".

As well as eliminating the causes of elopement, the reform program has made the school a happier place for all its residents. In addition, an increasing number of them are leaving the institution (openly and legitimately) to work in the community. In fact, the School reports, the demand currently exceeds the supply. (17-8)

TV SERVICE SHOW FEATURES MENTAL DEFICIENCY

The parents of mentally retarded children and the children themselves recently took part in a half-hour television broadcast in Seattle, Washington, arranged by the state's Association for Retarded Children. The program was presented on a daily public service show on the city's only T.V. channel.

The broadcast featured the mother of a mentally retarded child who was the master of ceremonies. Another mother was interviewed on what it means to have such a child—the impact on family life, finances and normal children in the home. A teacher brought a group of her mentally retarded pupils to demonstrate special teaching materials and methods, and another group of the children showed how music is used to teach coordination and group activity. (17-7)

MUST CLARIFY CONCEPTS AND UNIFY EFFORTS TO GAIN PUBLIC SUPPORT, SAYS PRESIDENT

(Abstracted by permission of Dr. Kenneth E. Appel from his after-dinner speech at the Fifth Mental Hospital Institute.)

There are certain reflections I would like to share with you tonight. Some of them should perhaps only be said to psychiatrists, because my thoughts are critical ones.

I am going to speak of things which many of you know better than I. I am in private practice and a teacher of psychiatry, struggling with the organization of teaching under a small budget. I, too, am torn between ideals and practical possibilities.

In 1940 when I was asked to study the facilities for care of patients in state hospitals, I was appalled. Facilities and personnel were inadequate—it seemed almost to be a national disgrace. When I was appointed to the Board of Psychiatry and Neurology I was shocked to discover the lack of training facilities and the consequently inadequate training. Since then the reports of the A.P.A. Central Inspection Board have shown the absence of invididual psychotherapy and the herding – the crowding – in these places which are supposed to care for and treat emotionally disturbed people. There are exceptions—examples of vision, resourcefulness, even of heroism. But it was because of what I saw in most cases that I became one of the Consultants of the Mental Hospital Service of the A.P.A. when it was founded.

And now we have these Institutes at which men, overworked and harassed, organize to pull themselves up by their bootstraps—why? Not for monetary reward—not for prestige. But because they know there is a job to be done—a great humanitarian challenge.

What are the hindrances to the proper practice of psychiatry today? First of all, lack of public support, because of poor public relations. Information about the needs of the hospitals, the work of psychiatrists, is not sufficiently diffused, nor is the knowledge that help is available for the emotionally troubled.

Public Health Problem No. 1 is mental illness. There are as many people in mental hospitals as there are in all others combined. Yet the amount of research into the causes and possible cures are pitifully inadequate.

You have all read Walter Baer's article in which he publishes the figures about our nursing service in mental hospitals; only two-fifths of one percent of R. N.'s in this country today are engaged in the bedside care of mental patients.

Never in history has there been so much interest in psychiatry as in the U.S. today—literature, art, motion pictures, plays—all are filled with psychiatric discussion. The need and the potential response is there. Yet this response is not being canalized with constructive support.

Where is the fault? It is useless to blame one another; the blame lies with us all—superintendents, legislators, the general public, teachers. But perhaps the greatest responsibility lies with those of us who are in private practice.

We talk of bringing the hospital and the community together, yet we isolate ourselves with our patients in an ivory tower. I think we should send students into state hospitals for training. We should send part-time groups both to learn and to help out the physicians already there. Why could we not even make it mandatory for doctors to spend a few months in a public mental hospital before they receive state licensure?

Divided Against Itself

Psychiatry today is too dichotomized, too compartmentalized, too dogmatic, too arrogant. One school looks down upon another; our relations with our medical colleagues are bad; we do not realize the importance of selectivity of observation; we repress curiosity and our thinking is guided—all the things which we urge our patients to avoid. No wonder the public is confused and distrustful.

Then there are our differences with the psychologists, who ask us to what scientific scrutiny we have subjected our beliefs. In return, we only say to them "You are inexperienced. You do not understand our concepts." Yet no new definition of psychotherapy will solve our problems. Our own skirts are not scientifically or practically clean. The public does not accept our dogmatism.

I think we should frequently speak of psychiatric treatment rather than of psychotherapy. Psychiatric treatment is broader because it includes medical treatment. It is the study and treatment of physical and mental illness; it does not exclude collaboration with psychologists and other related groups.

We must clarify our concepts of health and disease and not get involved with such fringe problems. Time and custom will determine their outcome in any case. We must remain objective and tolerant.

Constructive Cooperation Needed

Finally we must work to overcome this disassociation of psychoanalysis and private practice from the hospital and from the psychotic patient. Dr. Bernard Bandler is working with Dr. Henry L. Brosin's Committee of the American Psychoanalytic Association to develop methods of constructive cooperation to bring this discipline into the body of psychotherapy, especially in public hospitals.

I look foward also to the day when each teaching institution will have a full-time psychoanalyst on its staff and scholarships will be made available to young men on the basis of their ability and intellect and not of their financial fortunes.

Our relations with medical colleges and general hospitals are not good either. We should work together with our medical colleagues in general hospitals and in conferences—not on theoretical grounds but with practical problems. I have appointed a Committee under Dr. Walter Bar-

ton to work with the A.M.A. to get State and County Mental Health Societies to meet with their corresponding medical societies to interpret what modern psychiatry is trying to do and the need for its integration into general medicine. These meetings will also develop suggestions about how psychiatry can better help general medical practice; we shall ask for criticism and suggestions for improvement. From this will come support from the medical societies for public psychiatry.

I hope that each State will soon have a mental health department with a qualified head to develop mental health programs in the state. This should no longer be left to hospital superintendents. We need public relations experts in the state systems to interpret the nature and causes of mental illness; to explain that it has natural causes, many of which are known, and many more discoverable; that we therefore need more funds for research; that many mental diseases are curable and many, we believe, preventable; that we can give better care and treatment with better personnel.

Also I am discussing with Dr. Wilfred Bloomberg's Committee on Public Information a scheme whereby each one of the thirty odd Committees of the American Psychiatric Association shall produce, once every three years, a comprehensive report of its work, to be sent to all state hospitals for use in addresses, radio and television talks, press conferences and other means of communication. Thus the A.P.A. will produce vital material about eight or ten times a year which state mental health leaders may present to their communities. This work should be done in collaboration with Dr. Blain's Washington office.

Some of these thoughts may have some relevance to the problems which the men in this room face. We should apply our knowledge and skills to the service of society. We must realize the social consequences of our work. Work, play, art, recreation, companionship and religion are cooperative journeys. They enhance self-realization and enable us to take steps toward achievement which is one of the great satisfactions in life.

EXHIBIT OF PATIENTS' CLOTHING AT LITTLE ROCK

After three days of examination of clothing under test and clothing in current use in public hospitals, delegates took an active part in the discussion led by Dr. Lucy Ozarin, Veterans Administration and a Member of the Committee on Clothing for Mental Patients. Comments from the floor were noted and will be incorporated into a set of principles which the Committee will work out in a meeting scheduled for November. These findings will be published in the December issue of MENTAL HOSPITALS.

Nation-Wide Follow-up Study Urged

In preparation for leading the discussion on "Follow-Up Studies of Patients After Formal Discharge", Dr. W. L. Jaquith, Director of the Mississippi State Hospital at Whitfield, conducted what he termed "a hasty survey" of 200 state hospitals in the forty-eight states. Out of the 180 replies received only four hospitals claimed a definite program for follow-up after absolute discharge.

There was little evidence from the literature, it was stated, that Dr. Jaquith's "hasty survey" was very far out of line. Of the thousands of papers on psychiatric follow-up studies published within the past ten years, Dr. Blain noted that there were perhaps ten that dealt with "the total output of a hospital". The overwhelming majority studied only specific types of cases, such as lobotomies.

In order to overcome this lack, which Dr. Blain termed "the largest single blank space in our knowledge", Dr. Jaquith suggested that all forty-eight states cooperate on a pilot study. He proposed that one hospital in each state should follow-up on fifty consecutive discharges over a five-year period. The pooled knowledge, which would thus be based on over 2,000 cases in all, would give mental hospital administrators some basis of comparison for individual studies.

Dr. George Jackson, of Kansas, and Dr. G. W. Davis, Jr., of Louisiana, both pointed out that such a project must consider the problems encountered by the Model Reporting Area in compiling uniform data, and suggested that some of the methods and definitions adopted by the M.R.A. participants be employed.

Since a project of this scope would be costly to conduct and to correlate, it was suggested that funds might be obtained from one or more interested foundations.

Other aspects of the topic covered several follow-up studies carried on by hospitals represented at the meeting, and their methods of gathering the data.

Hospital Administration Part of Therapy

The immensity of the modern mental hospital—9% of all hospitals are for mental patients, yet their bed capacity is approximately one half of the whole hospital bed capacity of the country—is one of the factors which makes their administration extremely complex, said Mr. Robert H. Klein, codiscussion leader with Dr. Winfred Overholser at the first day's topic "Strengthening Hospital Services Through Improved Administrative Practices."

The first part of the topic "Administration is Everybody's Business" was devoted to brief outlines of experimental training courses for hospital administrators. Dr. Crawford Baganz of the V. A. Hospital at Lyons, N. J. described the work of his Committee on Qualifications & Training Standards for Mental Hospital Administrators. Dr. R. C. Anderson of Topeka, Kansas, described a course in administrative psychiatry offered in a residency program at the Menninger Foundation, and Dr. Robert Wyers of Norwalk, California, described an administration institute which included several different hospital disciplines.

Some experimental functional organizational charts were discussed. Dr. Alfred P. Bay of Manteno State Hospital, Illinois, insisted that the superintendent could not delegate certain delicate responsibilities. Thus the personnel director, the public information director and the administrative director should be responsible, he thought, only to the superintendent. Dr. Tarumianz protested that this would over-enlarge the administrative function, especially for small institutions.

It was generally agreed however, that there could be no such thing as one ideal plan. Dr. Walter Rapaport of Agnew, Calif. pleaded for the right of each hospital to make its own rules and regulations, and its own functional charts to suit its own peculiar requirements. Mr. Klein reminded the group that administrative organization was merely a tool—not an end in itself.

The second part of Topic 1, "The Right People in the Right Places" emphasized the human relationships involved in hospital administration.

"The employee is a social animal, not a machine," quoted Mr. Klein.

Dr. Robert Wyers said that some turnover in personnel was not only to be expected, but was even desirable. However, the earlier screening could be done the better—preferably in the training and orientation stage.

Practical Human Relations

Dr. Paul Weitz, V.A. Hospital, Lyons, N. J. described a study on turnover which had been conducted there about five years ago. Employees who had resigned were contacted after all connection from the hospital had been severed. It was found that the reasons given on their resignation forms – "insufficient salary," "poor working conditions," etc.—were not the whole truth. In most cases the employee had felt that both himself and his contribution went unrecognized and unappreciated.

"We are becoming aware of these things," said Dr. Weitz. "After all, they are psychiatric problems. We passed on this information to the 'line officers' of the hospital—those who work with five, ten or twenty people and can get to know them pretty well. By applying our newly acquired knowledge, we cut employee turnover by about 50%. We can't always solve employees' problems but we should be aware of them."

Various practical problems were discussed—training methods, recruitment programs, chain of command, salaries and orientation and training programs.

Dr. Jones said that on a practical level rules on "What to do in case of —" were valuable. Each employee should be trained so that he could do the job the next step above him, and should in turn be training the person below him to do his own job.

Dr. Rapaport said that the mental hospitals of this country had made good progress despite difficulties. This was a tribute, he said, to the very high quality of the staff who worked in them. While we might have much to learn administratively from industry, not everything done in industry was necessarily good for use in a mental hospital.

"Tell Them Why!"

During the afternoon session, "Communication—the Heart of Good Administration," Dr. Irving Kartus of the Menninger Foundation stated that the average psychiatrist was apt to think of administration as a chore, a bore, and perhaps even as unnecessary. He should instead see administration as actually part of the general therapeutic effort. Good personnel administration required as high a degree of psychiatric skill as treating patients.

Dr. Benjamin Simon of Ring Sanatorium, Arlington, Mass. spoke of the psychology of communication, citing as an example of the fastest and least accurate media—the hospital grapevine!

"Among staff, the most effective means of communication is the education and training program," he went on. "In such programs, people can learn the principles behind psychiatric care, behind activities, behind the whole hospital work. With this knowledge, people will be able to be more flexible and tell you why they may have found it necessary to make changes. This is the most important thing I have to say about communications with your staff in the mental hospitals—*tell them why!*"

Dr. Hayden Donahue, Commissioner of Mental Health for Oklahoma, said that supervisory training, similar to that used in industry, was as necessary as any other kind of training. Inept supervision caused high turnover.

An integral part of good communication was good records, said Mr. Klein. The two overlapped considerably. Practical questions were: Are records kept in a useable form? Are they both useful and necessary? How do you eliminate the keeping of unnecessary records? Who decides they are unnecessary? How do you encourage people to use the records which are kept?

Dr. Ozarin said that while records were an integral part of patient care, sometimes the writing of them might be used as an excuse to keep away from the patient. How, therefore, should people spend their time? Patients recovered apparently by means

of their contacts with professional staff—should such staff take time away from patients to write extensive records?

Dr. Tompkins said in one V.A. hospital, such notes were used by the Director of Professional Education for research and training.

One difficulty, it was suggested, was that all too often doctors wrote records for doctors and nurses wrote records for nurses. It was rare that such records were made available to the aide who spent most of his time with the patient. The only purpose in keeping records was to make necessary information available to people who worked with patients. One doctor told of a "blue sheet"—simply a message of six or eight lines from the doctor to the nurses and aides regarding the patient. This message included a brief clinical summary and instructions on the management of the patient. Another workable idea was clinical case conferences at which doctors, nurses and aides took part.

One problem about such conferences was how to free ward personnel to attend. One hospital solved this problem by sending out all patients not due for review on a bus trip for the afternoon or otherwise entertaining them off the ward, thus leaving all ward personnel free to sit down and take part in the conference.

Communication With Public

What Dr. Overholser described as "communications of another type" were discussed at length. Representative Hall of Oklahoma said that hospitals must show legislators that they have a good program to carry out. They are competing for funds with other government services and must therefore show in black and white that extra appropriations would do good. Even if not specifically required, it was a good idea to furnish a line budget to each legislator. They might not all read it—but many would.

Dr. Tarumianz said that mental hospitals had no lobby but that all legislators had both an economic and a humane duty to perform by following the principles laid down by the American Psychiatric Association. This Association had laid down in its standards the minimum requirements for good hospital operation; what could be done to increase the number who could be discharged for outside treatment; what could be done by mental hygiene clinics and so on.

"It is sound economy," he said "not waste, to spend money for intensive treatment—and I do not mean only electroshock! I mean intensive psychotherapy which can only be given by trained professional personnel."

It was also stated that the amount appropriated for mental health and mental hospitals depends upon the pressure on the legislature, which can come only from organized public opinion.

Accident Analysis Needed for Safety

"Hospital fires are so spectacular, so dramatic, so horrible and so associated with large financial loss that they capture our attention and the attention of the public and the press," said Dr. Alfred P. Bay, superintendent of Manteno State Hospital, Illinois, joint discussion leader with Mr. Kent Francis of the National Safety Council on "Accident Prevention and Safety in Mental Hospitals."

"What would you say, however," he went on, "if I were to describe to you a catastrophe which had taken the lives of over 2,000 patients?"

Dr. Bay said that such an event did not happen on a single day nor in a single place. However, accidents due to falls, patient altercations and other types of injury not caused by fire, had in fact accounted for the deaths of 2,000 patients in Illinois mental hospitals during the past 30 years.

Mr. Kent Francis said the essence of the hospital safety problem could be divided into four categories: First, the need to know the problem by inspection of premises, study of records, classification of experience and consultation with safety experts; second, to submit the accident problem to the same kind of administration to which purchasing, records, financing and other aspects of hospital management are subjected; third, to remove, so far as possible, the physical hazards of building and equipment, and, finally, to control unsafe acts by training people in the correct way to do their jobs and conditioning their attitudes so that they will follow through on this teaching.

As a result of this discussion, a method suggested by Dr. Bay may be set up, whereby Accident Reporting Forms would be sent out to member hospitals of Mental Hospital Service, with the request that some one person in the hospital complete and return them to the Washington office. Results would be tabulated and sent to National Safety Council so that the Council could make conclusions available to us, together with materials to enable us to control the events in our hospitals which are causing the accidents.

APA Standards Committee Reports on Work

In the absence of Dr. Addison M. Duval, Chairman of the A.P.A. Committee on Standards, Dr. George W. Jackson, one of the members of this Committee, led the discussion.

The Committee, he said, was currently working on standards for psychiatric units in general hospitals. After some discussion the group decided that in a general hospital, psychiatry should be a separate service rather than part of another service.

What should this service be called, it was asked—the psychiatric service or the psychiatric unit? Another question was on how detailed standards for this purpose should be. What purpose should they serve? Were they merely a check list for an inspector—or should they include the guiding philosophy of the Committee? The general agreement was that the basic philosophy should be included, perhaps in the form of the "credo"—the 12 points, whether or not this section of the standards is to be a part of the general standards or complete in itself.

As soon as the present draft is completed and ready for publication, the Committee will begin work upon standards for out-patient clinics, private hospitals and state schools for the mentally deficient.

The Law and the Mental Hospital

Excerpts from the Academic Lecture given at the Fifth Mental Hospital Institute

By DR. HENRY WEIHOFEN, College of Law, University of New Mexico

(Abstracted by Permission of the Author.)

There are a great many legal rules that have important bearing on mental hospitals and their administrators. Most of these are technical and must be left to the lawyers. However, while a problem may be legal in the sense that it involves litigation or the drafting of a statute, its sound legal solution may depend upon a sound factual solution—and the facts may be in the field of psychiatry or of hospital administration.

The law governing the commitment, treatment and release of mental hospital patients is a typical example of a problem in which legal rules, to be sound, must be based on sound principles of psychiatry and hospital administration. Let me therefore raise some questions that the law has to deal with in this field, and ask what you think ought to be done about them.

Privileged Communications

In about 30 out of the 48 states, confidential communications made by a patient to his doctor are "privileged"—i.e. the doctor is not permitted to disclose them without the patient's consent. Leading writers on the law of evidence rather widely take the view that privilege does more harm than good, by preventing the discovery of the truth, and that it ought to be abolished.

In *psychiatric* cases, however, Dr. Manfred S. Guttmacher and I have taken the position in a recent book that the peculiarly close relationship of trust and confidence required between therapist and patient makes the situation a special one, in which it is important that confidentiality be respected. But—is it sufficiently important to outweigh the importance of getting the truth in judicial trials?

It would be helpful to know whether psychiatrists in the minority states find themselves handicapped by the possibility that they may be required to divulge on the witness stand the confidences of their patients, and whether their patients are more reluctant to talk than those in states where privilege does exist.

Where the privilege exists, it usually applies only to physicians. To what other classes of persons should it perhaps be extended—clinical psychologists, psychiatric social workers or other technicians who practice psychotherapy but who are not M.D.'s?

Now let us turn to the situation in states where there is no legally protected privilege. You have been summoned to appear in court, you have been put in the witness stand and asked to divulge confidential details told to you by a patient. You might feel that divulgence would constitute a breach of professional ethics. Assuming that the odds are that you will be held in contempt of court if you refuse to testify, what do you do?

Voluntary Commitment

There is general agreement that it would be therapeutically helpful if patients came to a mental institution voluntarily instead of being "committed" by a court. Forty out of the 48 states have enacted so-called voluntary commitment provisions.

But how effective are such provisions? At least some of the hospitals are so over-crowded that there is no room for voluntary patients. Even if the hospitals have the room, how many such people are mentally capable of signing themselves into a hospital? I read recently that "only a small percentage . . . are capable of the volition required." If this is true, then voluntary admission is not practicable in very many cases. What can be done to hold voluntary patients who tire of the hospital routine after a few days and demand their release? All these questions are really aspects of the larger question, what can be done to increase voluntary as against involuntary hospitalization?

Release—Habeas Corpus

Every once in a while a patient or his relatives reach the conclusion, before you do, that the patient is recovered and entitled to his release. If you disagree, you may find yourself served with a writ of habeas corpus.

There are two horns of this dilemma—the preservation of individual liberty by permitting appeal from the hospital superintendents to judges untrained to determine psychiatric questions, or administrative finality with no safeguards against absolutism and abuse. We should be able to find a happy mean that will give the individual the protection of an impartial hearing and yet give some assurance that the hearing will lead to scientifically sound results.

I wonder if there has been any study made of individuals who are released by the courts as recovered, over the opposition of the hospital authorities? It is possible that a study of one hundred or more cases might show that a large number gave rather clear proof that they were not recovered and perhaps had to be recommitted. This would have a very salutary effect in leading judges to be very cautious in substituting their judgment for that of the hospital authorities. On the other hand, if such a study showed that persons so released were making good, it might give the hospital staffs something to think about. We must not rule out the possibility that hospitals are perhaps too conservative in their release policies.

A source of abuse is the repeated application for release. What should we do about this? Limit the frequency with which applications may be filed? Law must speak in general terms. Can a legal rule be drafted that will fit equally all types of mental disorder? The Draft Act Governing Hospitalization of the Mentally Ill provides a flexible procedure that may meet the need.

The "Psychopathic" Patient

What about the patient who is not psychotic but who shows a high degree of recidivistic anti-social behavior—the so-called "psychopath"?

Your therapy has been wholly ineffectual, he is just as anti-social as he ever was and you see no reason to believe you can ever do anything for him. Should he be released?

On the one hand, you cannot ignore the danger to the public. Nor should you wholly ignore public criticism were such a patient to commit a serious crime soon after being discharged by the hospital as "sane." On the other hand, these individuals are a nuisance in the hospital. And they are equally a headache in a prison.

It has been suggested that we build special institutions for these persons—of a correctional nature, but psychiatrically oriented. The financial cost of such a plan might be met by some kind of interstate cooperation.

Civil Rights of Patients

The "bill of rights" for patients, contained in the Draft Act, specifies the patient's right to communicate by sealed mail, to receive visitors and to exercise civil rights, including the right to dispose of property, make contracts and to vote, except insofar as one may have been declared incompetent to exercise such rights.

In the absence of such a provision, courts are inclined to assume that commitment means incompetency. This seems wrong.

Liability for Damages

It is my impression that negligence and malpractice suits against physicians are on the increase. Shock treatments, lobotomies and sterilization operations are particularly prone to result in such suits.

Claims for malpractice and alleged negligence are very troublesome to hospital administrators. Successful defense of such claims calls for skilled investigation procedures and competent legal handling. Hospitals subject to legal liability should therefore consider insuring and they should interest themselves in insurance rates and hospital provisions. Not all insurance companies are familiar with hospital administration practices and problems. Conferences between hospital administrators and the insurance companies could help by permitting an exchange of information about each other's problems.

What about psychosurgery? A real question may arise whether a mental patient is capable of giving intelligent and binding consent to an operation. Getting the consent of the man's relatives is no substitute. I can only suggest that some liberalization of the law may be in order and that meantime you be cautious about operating without the person's intelligent consent.

The questions I have discussed can be resolved correctly only with your counsel and assistance, despite the fact that some of them are rather technical legal questions. They are the legal rules which largely circumscribe your work. They fix your liabilities and duties and prescribe how you may or must perform your functions. These shortcomings have their immediate impact on you and your cooperation is essential if they are to be improved.

Need for Therapies Evaluation

"The Effectiveness of Therapies" session was keynoted by Dr. Paul Hoch, of the New York State Psychiatric Institute. Dr. Hoch said there is critical need for psychiatric evaluation of the therapies now used—the status of therapy is vague and undefined.

"There is a complete lack of methodology. There is a conspicuous lack of controls. There is a high rate of spontaneous remissions," he said.

Dr. Hoch deplored the lack of qualitative as well as quantitative studies. Too often the criteria for improvement are based on impressions rather than facts, he said.

Dr. Hoch described the project to be sponsored by the A.P.A. Committee on Evaluation of Therapies. Four to six hospitals on the Eastern Seaboard will be selected, in which a basic uniform methodology will be applied to study psychotherapy and psychosurgery in chronic patients.

Dr. Crawford N. Baganz, Manager of the Lyons (N.J.) V.A. Hospital, said that he hoped some standards of evaluation could be issued, no matter how arbitrary, which could be revised in time in the light of experience. Dr. Hoch mentioned that psychiatry must work with composite standards until more is known of the etiology of the diseases.

Governors to Confer on Training and Research

Rather than discuss the problem of mental health inadequately and hurriedly at this year's Governors' Conference, the governors voted unanimously to hold a National Governors' Conference entirely devoted to this problem, Mr. Sidney Spector, Director of Research of the Council of State Governments told delegates at the Mental Hospital Institute. This conference will be held in Detroit next February 8th and 9th.

Mr. Spector acted as discussion leader for the plenary session on "Training and Research in State Mental Hospital Programs," in place of Hon. Frank Bane, Executive Director, who was unable to be present. Copies of the summary and recommendations of the Council's recent publication were made available to the group.

Mr. Spector said that the publication of this and of the previous report had revealed sufficient data to justify and require some specific steps to put the recommendations into effect. The governors had therefore directed the Council of State Governments to establish an interstate clearing house to organize effective programs of interstate co-operation on the mental health problem, utilizing, so far as possible, existing agencies.

Such a clearing house will disseminate to all the states information about care, treatment and prevention of mental illness. Ways and means will be devised to secure, tabulate and analyze such information on a regular and continuing basis, so that every state can profit from the experience of the others.

Mental health today is the second most expensive activity which state governments must meet. While care and treatment require the major share of each state's mental health resources, ultimate reduction of admissions to mental hospitals cannot be achieved without better means of treatment and prevention. Nor can existing treatment methods be used effectively with insufficient trained personnel. Research and training therefore, are the twin arms to launch a pincer attack upon one of man's oldest enemies—mental illness.

Malpractice Insurance A Grave Problem

Dr. G. H. Gerow, Physician in charge of the Westport Sanitarium, Conn., opened his discussion of Malpractice Insurance and the Mental Hospitals by reviewing the discussions which had taken place between the American Psychiatric Association and Lloyd's of London in relation to coverage for all types of malpractice.

Dr. Gerow told the group that no domestic insurance company, with very few, insignificant exceptions, would write new policies to cover malpractice and that there was a growing tendency to refuse renewal of existing coverage. One reason was because of poor reporting so that the accurate statistics needed by insurance companies were not available. The present Lloyd's representatives feel that they can cover malpractice approximately 10% lower than previous existing rates, provided they get sufficient policies. "Spread of risk" is sound insurance practice; if they insure many private psychiatrists and hospitals that are giving shock treatment and very few that are not, this would be unsound from their point of view.

The rates are based upon the number of beds, and both number and professional quality of personnel. No personal inspection is required. Rates of course, will vary from hospital to hospital.

Dr. Gerow strongly urged that the hospital, the resident physicians and the owners, landlords and tenants should be covered by one insurance company, even though scattered coverage with different companies might come a few dollars cheaper. Block coverage avoids confusion as to insurance liability—as for instance might occur if two physicians had been involved in the treatment of a plaintiff, and were covered by two separate companies.

It came as a surprise to many of the group when Dr. Winfred Overholser warned them that many states today, as well as the federal government, had waived their "sovereign right" not to be sued, and in doing so, became responsible for the actions of their agents. While this was not true in all cases, said Dr. Overholser, there seemed to be a growing trend toward state governments accepting such liability.

One doctor asked what value a written release from the next of kin had in case a malpractice suit was brought by an electro-shock patient. Dr. Gerow said that Lloyd's themselves were not sure what legal value such a release would have, although they emphasized the validity of obtaining such a release before giving electro-shock as a deterrent to suit.

Dr. Francis Kelly, Physician in charge, Brigham Hall Hospital, Canandaigua, N. Y., said that the time might come when the A.P.A.—perhaps even the A.M.A.—might be compelled to set up its own insurance group to cover the whole nation.

Job Training Plans Compared

Mr. Thomas B. Dillingham, of the Colorado State Board for Vocational Training, opened the discussion on "Job Placement and Training for the Mental Hospital Patient" with an account of his own State's program.

Other similar programs were described by delegates from Washington, Pennsylvania and California.

Dr. Frank Casey, of the Veterans Administration, Central Office, after talking about the Perry Point VA "Member Employee" program*, said: "While it is true that the mental hospital is not a vocational training school, the nature of the illness is such that rehabilitation and job training is actually a part of therapy."

Foster home care was often a very essential part of any rehabilitation program, and Dr. T. J. Hardgrove of American Lake V.A. Hospital defined some of the elements of home placement. First there was the need to find a home—the right kind of home; this was a matter of leg-work. No clubs, no churches, no community organizations were able to help very much. Second was the selection of the patient—to match him to the home. The social service worker had to know a good deal about the foster family and much about the patient's own background and personality; and finally, there was the question of paroling the patient.

Dr. Harold Witten, Superintendent, Central State Hospital, Norman, Okla., said that farming offered rehabilitation possibilities. He suggested that a section might be set up at next year's Institute to explore all the practical possibilities and problems presented in this activity.

Ward Activity Programs

Dr. Duncan Whitehead, Director of the Buffalo (N.Y.) State Hospital led the discussion on "The Use of Ward Personnel in Activity Programs." He described the plan at his hospital whereby aides are taught the value and basic skills of Occupational and Recreational Therapy. They are then encouraged to carry on activity programs on their ward. Each month there is a meeting of these aides to discuss problems and exchange ideas. A number of the nurses voluntarily attend these meetings.

The hospital now has 29 wards on which these day-long activity programs are carried on solely by the ward attendants. They attempt to group their patients so that the purposefulness of the activities is evident. Clustered together, for example, would be one patient who unravels cloth, another who winds the threads on spools, and the patient who weaves these.

Dr. Lucy Ozarin felt that while these aides are not intended to be occupational or recreational therapists, they should be taught some of the dynamics involved, since for many of the patients these ward activities are the only treatment received. She suggested also that convalescent patients with special skills could be used in the programs. Dr. Thelma Owen said that this was done at her hospital in Huntington, West Va.

Miss Elsie Ogilvie, Nursing Consultant to the A.P.A., echoed Dr. Ozarin's hope for psychodynamic orientation, as she felt it would increase the aides' potential in stimulating the patients' interests.

Dr. Whitehead stressed the importance of the hospital administration encouraging the ward activity aides by showing open interest in their programs.

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* See MENTAL HOSPITALS, September 1953, "Employment Plan for Patients Leads to Later Job Placement."

"Geriatric Architecture" Helps Activity Program

Dr. Maurice E. Linden, Norristown State Hospital, Pa. illustrated his topic "Geriatric Architecture" by an impressive exhibit of photographs, poster material and plans, not only of the unit in Pennsylvania, but of other plans for geriatric patient care. Some of this material was collated and bound into a handsome 20 page booklet and passed out to the delegates.

Dr. Linden spoke of the philosophy behind the plans, the rationale of care of the emotionally ill aged, and went into the programming in some detail.

The geriatric rehabilitation patients work on regular sleep, work, play and rest schedules at Norristown, and special attention is given to personal hygiene and appearance. So far as she is able, the patient herself is responsible for "bedside housekeeping." Careful attention is given to medical and surgical needs with active consultation and follow-up service; where possible, physical examinations and treatments take place in the dispensary of the building. Patients needing prolonged bed care are transferred to the infirmary or the medical-surgical unit. Patients greatly enjoy their privilege of decorating their furniture and placing non-inflammable decorative curtains at their windows.

Psychological therapies include group psychotherapy, twice a week; individual psychotherapy as scheduled and relationship between patients and specially trained psychiatric nurses.

Activities include ward chores, including the washing out of personal laundry in a specially designed area. Industrial employment available takes in housekeeping, work in sewing rooms, cafeterias and dining rooms, the beauty salon and outdoor work. Occupational therapy means scheduled arts and crafts, and hobbies. There is also a special program of "horticultural therapy" on indoor and outdoor gardens.

Rehabilitation includes physiotherapy, assistance from the State Bureau and social service placements, while all types of recreation and entertainment are available. Refrigerators are available for snacks, and patients often give small birthday parties, etc. in "visiting cubicles." Religious services and activities are encouraged in all faiths. As far as possible all the foregoing activities are developed for group participation.

Patients are allowed to express individual preference as far as possible —for instance, by using their own clothing, and making small adjustments in equipment to suit individual desires. They are allowed to keep such pets as birds and gold and tropical fish.

Research in Mental Deficiency

In the session on Research in Mental Deficiency, it was shown that such research is more imperative today than ever before. The size and the nature of institutions for mentally retarded have changed vastly with the discovery of antibiotics, for one thing. Many congenitally defective children who would formerly have died at birth, or before, now are saved and many more survive childhood diseases. Then too, with the advent of parents' organizations and of community schooling for the higher-grade defectives, there are few of this type being admitted to institutions. The institution population therefore is becoming increasingly weighted with younger, lower-grade patients.

Dr. Gale H. Walker, who led the discussion, said that there appeared to be little relief in the future for the problems of housing and feeding this growing number. The solution therefore must lie in research to uncover the causes of mental deficiency and to aim for prevention.

Dr. Leslie Angus, Director of Research for the Woods School, Pa., spoke on the psychobiological aspect of research in mental deficiency.

In selecting cases to treat with psychotherapy, he said, the primary consideration should be the individual's ability to communicate, and not just his intelligence level.

Dr. George A. Jervis, Director of Laboratories, Letchworth Village, N. Y., said that this research can expect significant advances only after the full support of the other basic medical sciences has been enlisted. He suggested that there be more internships and residencies established in the field.

Fundamentals in Dietetic Practice

Mrs. Anna M. Dunn, Lincoln State Hospital, Neb., discussion leader on "Recent Developments in Dietetics and Kitchen Equipment," opened the session by saying that the nutritional needs of mental patients are the same as for anybody else. "Moreover," she said, "food is a most important part of therapy."

Mrs. Dunn reviewed briefly examples of good modern kitchen equipment, stating that, starting on January 1st, the National Sanitation Foundation will issue a seal of approval for equipment which is considered good.

In the interests of cleanliness, fixtures on casters make floor cleaning easy; a range which channels grease from frying to a container keeps floor and equipment clean and safe.

"One piece of equipment we could not do without is the rotary oven," she said. "A whole meal can be prepared in it, and it needs only one or two operators. Steam kettles too are indispensable. They should be seamless, with no right angles for easy cleaning. They are good for cooking vegetables; a number of small ones are better than a few large ones. This enables cooking to be done in stages so that vegetables for dining rooms farthest away from the kitchen can be cooked first."

Mrs. Dunn strongly emphasized the value of a training program for kitchen help.

With regard to the dining area, the cafeteria is generally considered the most suitable arrangement; one problem in Nebraska was that attendants tried to rush the patients through meals; now the supervisor clocks them and they must allow patients a full half hour.

Tables of different sizes—for 2, 4 and 6—are excellent. Long tables are not considered suitable.

The main advantage of the cafeteria of course, is the opportunity for patients to choose their own food. Dr. Chambers said that this choice is essential; it wakes up the kitchen—employees love to bring in new menus. Moreover, it is economical—when patients take what they want, waste is cut down.

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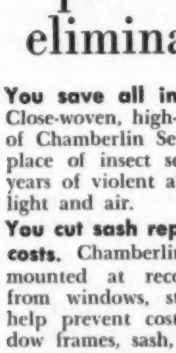

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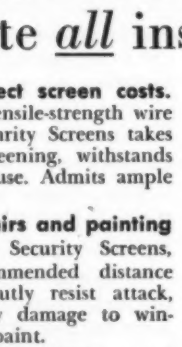

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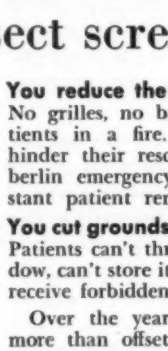

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QUICK NOTES

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They reduce cost of medical care for physical injury: prevent self-damage and attacks on attendants with broken glass. Prevent cold-inducing drafts. Prevent suicide attempts by hanging from window muntins, grilles, bars. Prevent receipt of dangerous pass-in objects.

They provide more cheerful atmosphere. Supplant depressing jail-like bars and grilles. Make room interior more homelike; keep building's exterior uncluttered. Admit ample light and summer air.

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Psychiatric Leaders Testify on Need for Research

"Perhaps the most significant development is the evolution of psychodynamics and the use of group methods to implement this science," Dr. Daniel Blain, A.P.A. Medical Director, told the House Committee on Interstate and Foreign Commerce on October 8th.

After outlining current research on psychosurgery, shock therapies and "total push," Dr. Blain spoke of research now taking place to determine how the social milieu of the hospital effected the possible recovery of the patient.

"The concept of the mental hospital as a part of a community network of psychiatric services—each interrelated to the other—is gaining acceptance . . . keeping more patients out of the hospitals and helping those who are discharged to readjust to community life," he continued. "The American Psychiatric Association makes a persistent effort to raise standards of administration in the hospital to the end that what personnel is available may be used most effectively. The Association has recently established a committee to certify qualified mental hospital administrators."

Dr. Blain was representing the American Psychiatric Association at one of the Congressional enquiries held by the committee under the chairmanship of Charles A. Wolverton of New Jersey, relating to the causes and control of some of man's principle diseases. The mental illness hearings, led by Dr. Bernard S. Wortis, of Bellevue Medical Center, New York, covered (1) information relative to causes and control of mental disorders; (2) the magnitude and direction of research and distribution of diseases; (3) coordination of research and dissemination of information among private and public agencies in the field; and (4) whether additional legislation, coordination or funds may be desirable or necessary to bring more effective progress into the program.

Dr. Robert H. Felix, Director of the National Institute of Mental Health, presented studies on admission and discharge rates, epidemiological studies and other data, and outlined the resources and services already provided for research. He explained in some detail the purposes of the clinical research center at Bethesda.

Dr. Fillmore Sanford, Executive Secretary of the American Psychological Association, said that while the science of human behavior was very young, there was no reason why it should not become sound and systematic. Within the limits at present imposed by shortages of money and trained people, the knowledge we have was being applied with intelligence and effectiveness.

Mr. Charles Schlaifer, Co-Chairman of the National Mental Health Committee, said that after a study of pilot programs in the psychiatric field, he was convinced that the nation's mental hospital population could be reduced by one-third by means of an all-out educational program for psychiatric personnel and the application of already known treatments both to potential hospital patients and to newly admitted patients. An all-out research program to exploit promising leads recently developed could produce new treatments for the major psychoses.

Inadequacy of Funds

Dr. Blain outlined some of the major unknown factors in the treatment and diagnosis of mental illness, and said that at present only about $4.25 per mental patient was being spent on psychiatric research as compared with seven or eight times that amount for cancer and polio. Related inadequacies in the field of mental illness were man power for research and research facilities. On the other hand, there was great potentiality for good research, if the present defects in allocating research money could be overcome.

"Much would be gained," he said, "by making financial support available to research workers with no other binding directive than a simple go-ahead signal to proceed where they will.

"In conclusion, I should like to say categorically that any proposed research in this field which is certified as a sound proposal by outstanding leaders in the field should receive whatever financial support it needs to be carried out," Dr. Blain finished. "The amount now spent yearly on psychiatric research is around $6,000,000. If it were to jump to 13 or 30 million or more, it would be a small figure indeed to devote to an all-out effort to empty the mental hospitals of America." (27-10)

Administration

SUGGESTION BOX AIDS INTER-STAFF RELATIONS

Topeka (Kans.) State Hospital reports that the Suggestion Box installed a few months ago to improve hospital operation has been even more successful in improving employee morale.

The hospital administrators felt that a Suggestion Box would be a means of bringing forth ideas from all levels of personnel, especially those too modest to broach their ideas directly to the administrators. They realized that there would be a number of anonymous "gripes" submitted, but even these have been of certain value.

On the whole, however, the suggestions have been seriously thought out and practical. A cash prize is awarded for the best suggestion each month. The prize-winning idea is then published in the employees' newspaper.

All suggestions are considered by a committee of five, representing the major areas of the hospital. They make recommendations to the Acting Superintendent, Dr. Clark Case, regarding the best ideas submitted. They also advise him on replies to all employees who have made suggestions.

Many of the things suggested are not practicable, and the Suggestion Committee points out the reasons to the employee. Often the suggestions indicate that the employee is not familiar with facilities already available.

The employees have reacted favorably to the Suggestion Box system, and Dr. Case feels it will prove beneficial. "It has enabled me to pick up some dissatisfactions in our personnel policies that I probably otherwise would not have learned so quickly," he added, "The Suggestion Box seems to have considerable promise to help both employee morale and operation of the hospital." (1-10)

Psychiatric Social Worker in the General Hospital

By FANNY HOUTZ

Psychiatric Casework Supervisor
Mental Health Service
Denver Dept. of Health & Hospitals

Traditionally the social worker helps the psychiatrist by interviewing families, and contacting agencies or individuals for social history information. This helps in establishing the facts about the patient's social and economic condition and in determining the diagnosis. However, in the 24-bed psychiatric ward of this general hospital, we have found that by integrating casework skills with the program of the total hospital team, psychiatric social workers can offer additional essential service.

The hospital is a public one, and our service is geared to emergency and acute illness. Our patients are often transients rather than residents. The maximum stay is three months, the average 25 days.

The psychiatric social work staff consists of three trained psychiatric social workers who give part time to the ward and part time to two psychiatric out-patient clinics; they work under a qualified psychiatric casework supervisor. In addition they have a regular program of consultation with staff and resident psychiatrists. They attend ward rounds and staff meetings.

On admission each patient is assigned to a social worker as well as to a resident psychiatrist. The social worker, in his routine work of establishing contacts with families, friends, ministers, employers, landlords and social agencies, is also establishing relationships which can be of real value. The patient's family are helped with their feelings of guilt or anxiety about his illness. They are more ready to accept the need to sign legal papers for treatment or for commitment to the State hospital if this is necessary. When a patient is transferred to the State hospital, we urge families and friends to keep in touch with him through mail and visits, and to be ready to help him when he returns to the community.

Families are encouraged to keep in touch with our Social Service workers following the patient's discharge, so that we may help them with any problems which may then confront them. This continuing relationship with family or friends has often been a factor in delaying or preventing further hospitalization. Through help to the family in a troublesome situation or through their encouragement to him to return for out-patient treatment, it is often possible for the patient to handle some crisis so that he does not again become acutely ill.

In selected cases, the resident psychiatrist and the social worker work with the same patient. This is usually one who is returning to the community but who has no family or must return to a disturbed family situation. In this cooperative treatment program the psychiatrist deals with the intrapsychic problems, and the social worker concentrates on problems in inter-personal relationships and in helping the patient with reality planning after discharge – i.e., with job, financial planning, living quarters, etc. In a situation like ours where the direct work with patients is done by resident psychiatrists who change service frequently, the psychiatric social staff provides continuity.

Numerous illustrations can be cited of patients who are carrying on in the community, instead of being confined to a State hospital, because social service assistance was available during a period of stress.

ARCHITECTURAL STUDY

Getting Under Way

By JOHN M. SMALLDON, M.D.

Director, Architectural Study Project

With the arrival of our architect, Mr. Alston G. Guttersen, and the first meeting of a consultant committee of psychiatrists and architects, the Hospital Architectural Study Project is now under way. First steps involve the collection of plans and specifications on recent and proposed mental hospital construction, and the accumulation of bibliographic material.

Enlargement of the consulting group to the study is awaiting acceptances from the psychiatrists and architects approached. The architects are being appointed by the President of the American Institute of Architects, which is cooperating with us in this project.

Plans for dissemination of the material to be developed include the use of several pages of MENTAL HOSPITALS each month for descriptive matter, cuts and plates. The circulation of this magazine, therefore, is to be extended to interested architects in addition to the present distribution to mental hospital personnel and mental health authorities.

The preparation of loose-leaf bulletins to form a constantly up-to-date manual on mental hospital design, construction and equipment is also contemplated. Architectural journals have expressed an interest in running progress reports on the project. The assistance of an engineer and of draftsmen will become necessary.

It is hoped that the assistance of several A.P.A. Committees, as well as of individual members of mental hospital staffs throughout the United States and Canada may be obtained to study space requirements in hospital buildings for treatment facilities, recreation, occupational therapy, the training of personnel, etc. As the work of the Study develops, it is expected to become international in scope.

Later plans include the use of graduate architectural students in field work assignments, and laboratory research through cooperative arrangements with schools of architecture.

To complete our roster of recent mental hospital construction as well as construction in the planning stage, we are requesting hospital people and mental health authorities to cooperate by reporting the work to this office. Much new hospital construction is in progress or is in the planning stage, and we urgently need full information about it, whether it is concerned with public or private mental hospitals, hospitals for the mentally deficient, psychiatric units in general hospitals, clinic buildings, units for children or other specialized facilities in the field.